

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVS108AGC</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/09/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHARLESTON RES. CARE HOTEL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2121 W CHARLESTON BLVD</b> <b>LAS VEGAS, NV 89102</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments  Surveyor: 27364  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.  This Statement of Deficiencies was generated as a result of a complaint investigation conducted in your facility on 12/9/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.  The facility is licensed for 129 Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness. The census at the time of the survey was 129.  Complaint # NV 00023828 was investigated. The complaint was not substantiated.  The following unrelated deficiency was identified:	Y 000		
Y 178 SS=D	449.209(5) Health and Sanitation-Maintain Int/Ext  NAC 449.209 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained.  This Regulation is not met as evidenced by: Surveyor: 27364	Y 178		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 178	<p>Continued From page 1</p> <p>Based on observation and interview on 12/9/09, the facility failed to ensure damage to the ceilings in 2 of 11 resident rooms were repaired (Resident room # 211 and #228).</p> <p>This is a repeat deficiency from the 3/25/09 survey.</p> <p>Severity: 2 Scope : 1</p>	Y 178			

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